Return to Work Evaluation

PART 1 SUPERVISOR: Please complete Part 1 and return it completed to:

_____

_____

Employee's Name_____

Date of injury/illness _____

Nature of injury/illness_____

Job title and description of duties_____

_____

_____

_____

What protective equipment is required?_____

_____

PART 2 PHYSICIAN: To assist your patient's return to work, please complete Part 2, sign the form and return this form to: _____

_____

Diagnosis_____

_____

Is Patient able to do regular work: _____

_____

If not, but patient is able to do some work, please complete the work activities listed below.

If the patient is totally unable to work at this time, please estimate the period of disability. _____

_____

In an 8-hour work period, how many consecutive hours are spent doing the following activities:

	Number of hours			
	6-8	4-5	1-3	0
Sitting				
Standing				
Walking				
Pushing				
Pulling				
Twisting				
Climbing				
Balancing				
Bending				
Kneeling				
Crawling				
Reaching				
Grasping				
Performing repetitive movements				
Working Outdoors				
Working indoors				
Working in temperature extremes				
Working at heights				
Comments:_____ _____				

How many consecutive hours can patient perform these activities?

Number of hours			
6-8	4-5	1-3	0

Weight Handling Frequency

	Number Per/Hr			
	15 Or More	10-15	1-10	0
Lifting & Carrying				
a. Less than 10 pounds				
b. 10-20 pounds				
c. 20-50 pounds				
d. 50-100 pounds				
e. Over 100 pounds				

Patient Can Handle Per/Hr.

15 or More	10-15	1-10	0

Employee's job can be modified? _____Yes _____No
Other work is available? _____Yes _____No

For what period of time will the above evaluation be appropriate:

_____

Signature _____

Title _____

Date _____

UW- _____

Address _____

Comments:_____

_____

_____

Date_____ Signature _____